STATEMENT OF

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TO THE

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VETERANS AFFAIRS PHYSICIAN AND DENTIST COMPENSATION

WASHINGTON, D.C. OCTOBER 21, 2003

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to thank you for allowing us to comment on this important subject.

Members of the VFW and all veterans have a vested interest in the compensation system of the Department of Veterans Affairs' (VA) health care providers. We believe that to remain competitive with the private sector, VA must be allowed greater flexibility in setting compensation levels for its health care providers.

Unfortunately, and to the detriment of veterans, VA does not currently have this payroll flexibility and the current salary structure has been in place since 1991. Consequently, VA's physician pay lags far behind what the private sector can pay--in certain specialties by as much as 67%.

As a result, the recruitment and retention of quality health care physicians has become increasingly difficult, especially in certain critical specialties. System wide, VA is nearly 2000 full-time physicians short. Further VA is over 100 physicians short in specialties such as Anesthesiology, cardiology, gastroenterology, internal medicine, psychiatry and radiology. VA just is not able to compete with the salaries offered by the private sector.

To some extent, VA can overcome this disadvantage. Doctors at VA have a significant burden lessened in the amount of malpractice insurance they must carry, resulting in a substantial savings for them. Additionally, their affiliations with many medical schools affords their doctors

increased opportunities for research, as well as additional compensation possibilities through the school. In some areas, however, this is not enough. And in certain facilities, where there is no medical school affiliation, it is impossible altogether.

To compensate for the employment shortfall, VA must, in effect, shoot itself in the foot. VA contracts for care from local physicians at prevailing market rates. VA will not pay these rates to actually put a physician on staff, yet they will pay these higher rates to have this physician work alongside other VA staff. This does not make any sense.

When combined with the growing numbers of veterans seeking access to VA health care, the inability of VA to fill these provider positions is a contributory factor towards the access problems that plague the VA health care system. With a full health care staff, it is likely that the nearly 100,000 veterans who have been waiting six months or more for their primary health care appointments would be significantly fewer and that we would hear fewer horror stories of two-year waits for specialty care appointments.

Providing proper physician compensation is necessary to ensure that our nation's veterans receive the first-rate timely health care they earned through their service; these two issues are directly intertwined. As such, we would endorse any legislation that would increase the recruitment and retention of quality physicians and health care providers, thereby improving the quality of care our nations' veterans receive.

This concludes my testimony. I would be happy to answer any questions that you or the members of the Subcommittee may have.